AMENDED IN ASSEMBLY JUNE 8, 2000

AMENDED IN ASSEMBLY MAY 16, 2000

AMENDED IN ASSEMBLY JULY 8, 1999

AMENDED IN SENATE MAY 28, 1999

AMENDED IN SENATE MARCH 8, 1999

SENATE BILL No. 87

Introduced by Senator Escutia

December 7, 1998

An act ~~to add Section 14005.31 to~~ *to amend Section 14005.81 of, and to add Sections 14005.31, 14005.32, 14005.33, 14005.34, 14005.35, 14005.36, 14005.37, and 14005.38 to,* the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 87, as amended, Escutia. Medi-Cal: eligibility.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services.

Under existing law, one of the bases for eligibility is the receipt of CalWORKs benefits.

This bill would provide for a rebuttable presumption of Medi-Cal eligibility for Medi-Cal beneficiaries whose CalWORKs benefits have been terminated. *The bill would provide for the transfer of a Medi-Cal beneficiary's benefits to an appropriate transitional Medi-Cal program, under*

specified circumstances. It would also provide for eligibility redetermination procedures *when a Medi-Cal beneficiary's circumstances change so as to affect his or her eligibility generally, and specifically in* cases in which the CalWORKs benefits of Medi-Cal beneficiaries have been terminated.

Because each county is required to administer Medi-Cal eligibility determination provisions, the bill would constitute a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 14005.31 is added to the Welfare and Institutions Code, to read:

14005.31. (a) When aid to a family under Chapter 2 (commencing with Section 11200) is terminated, family members shall be presumed eligible for benefits under this chapter pursuant to Section 14005.30, unless the county has information that clearly demonstrates either of the following:

(1) Family members are eligible under this chapter pursuant to other provisions of law.

(2) A circumstance exists that requires termination of Medi-Cal eligibility.

(b) The presumption of Medi-Cal eligibility provided for in subdivision (a) shall be deemed a redetermination of the Medi-Cal eligibility, unless the presumption is rebutted. Failure to submit a CalWORKs reporting form

shall not in itself rebut the presumption of eligibility provided under subdivision (a).

(c) When an individual's basis of eligibility for benefits under this chapter changes from the receipt of aid under Chapter 2 (commencing with Section 11200) to any other basis, including that of being presumed eligible in accordance with subdivision (a), there shall not be a period of ineligibility for the receipt of Medi-Cal benefits.

(d) The department shall, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, prepare a simple, clear, consumer-friendly notice to be used by the counties, in order to inform beneficiaries eligible in accordance with subdivision (a) that their Medi-Cal benefits will continue. The notice *shall be sent out at the same time as the notice of discontinuation of cash aid, and* shall include all of the following:

(1) *A statement that* Medi-Cal benefits will continue even though aid under Chapter 2 (commencing with Section 11200) has been terminated.

(2) ~~The~~ *A statement that the* beneficiary shall be required to submit ~~a status report as defined in subdivision (j). The first report shall be due in three months in order for benefits to continue after a period of three months. The notice shall contain the specific date on which the first status report is due. A copy of a status report form shall be included with the notice.~~

~~(3)~~ *an annual reaffirmation form, as defined in Section 14005.38.*

(3) A statement that the beneficiary is also required to report significant changes that may affect eligibility or share of cost to the county within 10 days.

(4) A telephone number to call for more information.

~~(e) The department shall adopt a mechanism to distinguish between cases of persons eligible for Medi-Cal benefits under Section 14005.30 pursuant to subdivision (a) and those whose eligibility under that section is due to other reasons. The mechanism shall be adequate to inform managed care plans, in a timely manner, of the fact that a beneficiary's basis for Medi-Cal eligibility has~~

~~changed to that described in subdivision (a) and about the actions that will be required to be taken, and the timeframes for taking these actions, in order for eligibility to continue beyond the first status report required under paragraph (2) of subdivision (d). This mechanism shall include a method of informing managed care plans, when applicable, that the 30-day period of eligibility provided for in subdivision (h) has commenced.~~

~~(f) (1) During the first three months in which an individual receives Medi-Cal benefits in accordance with subdivision (a), the county shall undertake outreach efforts to beneficiaries in order to maintain the most up-to-date home addresses, telephone numbers, and other necessary contact information and to encourage timely submission of status reports. In implementing this subdivision, a county may collaborate with community-based organizations, so long as confidentiality is protected.~~

~~(2) Every contract between the department and a managed care plan shall contain the following requirements:~~

~~(A) Each plan shall communicate with its enrollees, in writing, via telephone, or through the plan's provider and point-of-service networks, in order to maintain current enrollee contact information and to encourage timely submission of status reports. The duty to encourage timely submission of status reports shall include contacting beneficiaries both prior to the date when a report is due and upon notification by the department that the 30-day period of eligibility subsequent to the failure to submit a timely or completed status report, as provided for in subdivision (h), has commenced.~~

~~(B) Each plan shall also share updated information with the county on a monthly basis.~~

~~(3) The department and each county shall incorporate, in a timely manner, updated contact information received from managed care plans pursuant to paragraph (2) into the beneficiary's Medi-Cal case file and into all systems used to inform beneficiaries of their~~

~~enrollee status, unless there is reason to believe the contact information received is not accurate.~~

~~(g) Unless immigration status has changed, a beneficiary eligible in accordance with subdivision (a) shall not be required to supply any documentation with his or her status reports. This subdivision shall not, however, affect the authority of the department to verify eligibility through other means or to request documentation if the county has facts clearly conflicting with information provided in the status report. The department may conduct random sampling of eligibility.~~

~~(h) (1) If a beneficiary eligible in accordance with subdivision (a) fails to provide the status report at the end of the first three months as required under paragraph (2) of subdivision (d), or the report is incomplete, the beneficiary shall remain eligible for a period of 30 days, during which his or her eligibility shall be redetermined. If the beneficiary submits a completed status report within this 30-day period, it shall be deemed to have been submitted in a timely manner for purposes of determining eligibility.~~

~~(2) (A) A county shall, during the 30-day period of eligibility provided for in paragraph (1), make every reasonable effort to gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility. Sources for these eligibility redetermination efforts shall, whenever feasible, include, but are not limited to, an open or recently closed Medi-Cal, CalWORKs, or Food Stamp program case file of the beneficiary or of any of his or her family members, and the ''New Hires Registry'' compiled by the Employment Development Department.~~

~~(B) If a county cannot obtain information necessary to redetermine eligibility pursuant to subparagraph (A), the county shall, either directly or in collaboration with community-based organizations so long as confidentiality is protected, attempt to reach beneficiaries, during times which shall include evenings and weekends, in order to obtain this information.~~

~~(C) If a county's efforts pursuant to subparagraphs (A) and (B) to obtain the information necessary to redetermine eligibility have failed, the county shall send a blank quarterly report form to a beneficiary who did not return the form and a copy of the incomplete form with the missing information highlighted to a beneficiary who returned an incomplete form. The county shall accompany the forms with a simple, clear, consumer-friendly cover letter developed by the department in consultation with the counties and representatives of consumers, managed care plans, and providers, which shall explain why the status report is necessary, that it is not necessary to be receiving CalWORKs benefits to receive Medi-Cal benefits, and that even persons who are employed can receive Medi-Cal benefits. The cover letter shall include a telephone number to call in order to obtain more information. A beneficiary shall have 20 days from the date the form is mailed pursuant to this subparagraph to respond. Failure to respond prior to the end of this 20-day period shall not impact his or her Medi-Cal eligibility.~~

~~(3) If, within 20 days of the date of mailing of a form to the beneficiary pursuant to subparagraph (C) of paragraph (2), a beneficiary does not submit the status report or submits an incomplete report, the county shall send the beneficiary a written notice of action stating that his or her eligibility shall be terminated 10 days from the date of the notice and the reasons for that determination, unless the beneficiary submits a completed report prior to the end of the 10-day period.~~

~~(i) (1) When a beneficiary's aid under Chapter 2 (commencing with Section 11200) is terminated, and the county has information clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal benefits under this chapter, the beneficiary shall remain eligible for benefits for a period of 30 days, during which his or her eligibility shall be redetermined. If the beneficiary submits a completed status report, as provided under subparagraph (C) of paragraph (2), within this 30-day period, the status report shall be deemed to have been~~

~~submitted in a timely manner for purposes of determining eligibility.~~

~~(2) (A) A county shall, during the 30-day period of eligibility provided for in paragraph (1), make every reasonable effort to gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility. Sources for these eligibility redetermination efforts shall, whenever feasible, include, but are not limited to, an open or recently closed Medi-Cal, CalWORKs, or Food Stamp Program case file of the beneficiary or of any of his or her family members, and the ''New Hires Registry'' compiled by the Employment Development Department.~~

~~(B) If a county cannot obtain information necessary to redetermine eligibility pursuant to subparagraph (A), the county shall, either directly or in collaboration with community-based organizations so long as confidentiality is protected, attempt to reach beneficiaries, during times which shall include evenings and weekends, in order to obtain this information.~~

~~(C) If a county's efforts pursuant to subparagraphs (A) and (B) to obtain all of the information necessary to redetermine eligibility have failed, the county shall send a status report form to the beneficiary highlighting the missing information. The county shall accompany the form with a simple, clear, consumer-friendly cover letter developed by the department in consultation with the counties and representatives of consumers, managed care plans, and providers, which shall explain why the status report is necessary, that it is not necessary to be receiving CalWORKs benefits to receive Medi-Cal benefits, and that even persons who are employed can receive Medi-Cal benefits. The cover letter shall include a telephone number to call in order to obtain more information. A beneficiary shall have 20 days from the date the form is mailed pursuant to this subparagraph to respond. Failure to respond prior to the end of this 20-day period shall not impact his or her Medi-Cal eligibility.~~

~~(3) If, within 20 days of the date of mailing of a form to the beneficiary pursuant to subparagraph (C) of~~

~~paragraph (2), a beneficiary does not submit the status report or submits an incomplete report, the county shall send the beneficiary a written notice of action stating that his or her eligibility shall be terminated 10 days from the date of the notice and the reasons for that termination, unless the beneficiary submits a completed status report prior to the end of the 10-day period.~~

~~(j) For purposes of this section, "status report" means the reaffirmation of eligibility required to be provided in accordance with Section 14012. The status report form shall contain simple questions that will provide sufficient information to determine whether the beneficiary is eligible for benefits under any Medi-Cal eligibility category.~~

~~(k) The Legislature finds and declares that the provisions of this section are necessary to meet the federal requirements for continued federal financial participation.~~

~~SEC. 2.~~

SEC. 2. Section 14005.32 is added to the Welfare and Institutions Code, to read:

14005.32. (a) (1) If the county has evidence clearly demonstrating that a beneficiary is not eligible for benefits under this chapter pursuant to Section 14005.30 or subdivision (a) of Section 14005.31, but is eligible for benefits under this chapter pursuant to provisions of law, the county shall transfer the individual to the corresponding Medi-Cal program. Eligibility under Section 14005.30 shall continue until the transfer is complete.

(2) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall prepare a simple, clear, consumer-friendly notice to be used by the counties, to inform beneficiaries that their Medi-Cal benefits have been transferred pursuant to paragraph (1) and to inform them about the program to which they have been transferred. The notice shall be issued with the notice of discontinuance from cash aid, and shall include all of the following:

(A) A statement that Medi-Cal benefits will continue under another program, even though aid under Chapter 2 (commencing with Section 11200) has been terminated.

(B) The name of the program under which benefits will continue, or, if eligibility for Medi-Cal benefits has not yet been transferred to another program, an explanation that information about the program will be provided at the time the transfer occurs.

(C) A statement that the beneficiary is required to submit an annual reaffirmation form, as defined in Section 14005.38, and the specific date on which the annual form is due, in accordance with Section 14005.34.

(D) A statement that the beneficiary is also required to report to the county, within 10 days, significant changes that may affect eligibility or share of cost.

(E) A telephone number to call for more information.

(3) If the county determines that the individual is not eligible for benefits under Section 14005.30 or subdivision (a) of Section 14005.31, but is eligible for the transitional Medi-Cal program due to increased employment earnings under Section 14005.8 or 14005.81, a separate notice shall be prepared and used instead of the notice required under paragraph (2) of subdivision (a). In addition to the information identified in subparagraphs (A) to (E), inclusive, of paragraph (2), this notice shall also explain that no reporting is required for the first six months, but that a status report will be due in the seventh month. The notice required under this paragraph shall also include the specific due date for the report. The department shall coordinate this notice with the notices required under Sections 14005.76 and 14005.84 for transitional Medi-Cal.

(4) If the county determines that the individual is not eligible for benefits under Section 14005.30 or subdivision (a) of Section 14005.31, but is eligible for the transitional Medi-Cal program due to increased income from child or spousal support under Section 14005.85, a separate notice shall be prepared and used instead of the notice required under paragraph (2) or (3). In addition to the information identified in subparagraphs (A) to (E),

inclusive, of paragraph (2), the notice required under this paragraph shall also explain that no reporting of any kind is required, but that eligibility under this category will end in four months, at which time a redetermination pursuant to Section 14005.37 will be conducted to determine whether Medi-Cal eligibility exists on any other basis.

(b) No later than September 1, 2001, the department shall submit a federal waiver seeking authority to eliminate the reporting requirements imposed by transitional medicaid under Section 1931(b)(c)(2) (Title 42 U.S.C. Sec. 1396u-1(c)(2)).

SEC. 3. Section 14005.33 is added to the Welfare and Institutions Code, to read:

14005.33. A Medi-Cal case for which eligibility is established under subdivision (a) of Section 14005.31 or for which eligibility has been transferred pursuant to Section 14005.32 shall be assigned to a county eligibility worker within 10 days of this change in Medi-Cal eligibility. Within 10 days of the assignment, the county shall send the beneficiary the worker's name, address, and phone number, the beneficiary's Medi-Cal case number, and hours during which the worker may be contacted by the beneficiary.

SEC. 4. Section 14005.34 is added to the Welfare and Institutions Code, to read:

14005.34. For an individual whose Medi-Cal eligibility is continued pursuant to subdivision (a) of Section 14005.31, after benefits under (Chapter 2 (commencing with Section 11200) are terminated or whose Medi-Cal eligibility is transferred under paragraph (1) of subdivision (a) of Section 14005.32, the annual reaffirmation date under Section 14012 shall be 12 months from the date aid was granted. For all other beneficiaries receiving Medi-Cal without aid, the annual reaffirmation date shall be 12 months after the date that the Medi-Cal application was granted and Medi-Cal benefits were in effect, excluding the period of retroactive eligibility, if any.

SEC. 5. Section 14005.35 is added to the Welfare and Institutions Code, to read:

14005.35. (a) The department, in consultation with the counties and representatives of consumers, managed care plans, and Medi-Cal providers, shall adopt a mechanism to distinguish between those persons eligible for Medi-Cal due to the receipt of benefits under Section 14005.30 pursuant to subdivision (a) of Section 14005.31 and those whose eligibility under Section 14005.30 is due to other circumstances, such as eligibility for aid under Chapter 2 (commencing with Section 11200).

(b) The mechanism shall be adequate to inform managed care plans that a beneficiary's basis for Medi-Cal eligibility has changed to that described in subdivision (a) of Section 14005.31, or pursuant to a transfer as provided in Section 14005.32, the date the annual reaffirmation form is due, and, when applicable, the due date for a transitional Medi-Cal program report. The mechanism shall be adequate to make this information available to a plan as soon as is feasible, but in no event later than 30 days from the date the change or transfer has occurred.

(c) The mechanism shall include a method of informing managed care plans, when applicable, that the 30-day and 20-day periods of eligibility provided for in subdivision (b) of Section 14005.37 during the redetermination process have commenced, and of the due date for the redetermination form, if the form is needed after the ex parte review has been completed. The mechanism shall be adequate to make this information available to a plan as soon as feasible, but in no event later than 10 days from the date the 30-day period has commenced.

SEC. 6. Section 14005.36 is added to the Welfare and Institutions Code, to read:

14005.36. (a) (1) The county shall undertake outreach efforts to beneficiaries receiving benefits under this chapter and who do not receive aid, in order to maintain the most up-to-date home addresses, telephone numbers, and other necessary contact information, and to encourage and assist with timely submission of the annual

reaffirmation form, and, when applicable, transitional Medi-Cal program reporting forms and to facilitate the Medi-Cal redetermination process when one is required as provided in Section 14005.37. In implementing this subdivision, a county may collaborate with community-based organizations, provided that confidentiality is protected.

(2) Every contract between the department and a managed care plan shall contain the following requirements:

(A) Each plan shall attempt to communicate with its enrollees, in writing, via telephone, or through the plan's provider and point-of-service networks, at least once every six months in order to maintain current enrollee contact information and to encourage timely submission of the annual reaffirmation form and, when applicable, transitional Medi-Cal program reporting forms and the redetermination form provided for in paragraph (3) of subdivision (b) of Section 14005.37. This duty shall include attempting to contact beneficiaries both prior to the date when a form or report is due, and upon notification by the department that the 30-day period of eligibility as provided for in paragraph (1) of subdivision (b) of Section 14005.37 has commenced. A plan that communicates with its enrollee by writing or calling the enrollee at his or her last known address or telephone number shall be deemed to be in compliance with this section.

(B) Each plan shall forward updated enrollee contact information to the county on at least a monthly basis.

(3) The department and each county shall incorporate, in a timely manner, updated contact information received from managed care plans pursuant to paragraph (2) into the beneficiary's Medi-Cal case file and into all systems used to inform plans of their beneficiaries' enrollee status. The county may attempt to verify that the information it receives from the plan is accurate before updating the beneficiary's case file.

SEC. 7. Section 14005.37 is added to the Welfare and Institutions Code, to read:

14005.37. (a) Whenever a county receives information about changes in a beneficiary's circumstances that may affect eligibility for Medi-Cal benefits, the county shall promptly redetermine eligibility.

(b) Subject to paragraph (4) of subdivision (d), Medi-Cal eligibility shall continue during the redetermination process until the county makes a specific determination based on facts clearly demonstrating that the beneficiary is no longer eligible for Medi-Cal under any basis and due process rights guaranteed under this division have been met.

(c) A redetermination of eligibility shall include an exploration of all possible avenues for ongoing Medi-Cal eligibility, including, but not limited to, disability, and shall not be complete until the county either determines that the person is still eligible for Medi-Cal benefits or has facts clearly demonstrating that eligibility does not exist on any basis. Failure to submit a required reporting form shall not be considered a fact demonstrating that eligibility does not exist on any basis.

(d) (1) A beneficiary shall remain eligible for a period of a least 30 days while an ex parte review, which shall be the first step in the redetermination process, is conducted. During this period, the county shall take any reasonable steps to gather information available to the county that is relevant to the beneficiary's Medi-Cal eligibility. Sources for these ex parte efforts to redetermine Medi-Cal eligibility shall include, whenever feasible, but shall not be limited to, the Medi-Cal, CalWORKs, or Food Stamp program case file of the beneficiary or of any of his or her family members, if the file is open or has been closed within the last 45 days, and the "New Hires Registry" of the Employment Development Department.

(2) If a county cannot obtain all of the information necessary to redetermine eligibility pursuant to the ex parte review required by paragraph (1), the county, either directly or in collaboration with community-based organizations or managed care plans, or both, and

provided that confidentiality is protected, shall attempt to reach beneficiaries during times which shall include evenings and weekends, in order to obtain this information. Only information that is subject to change, that is absolutely necessary to complete the eligibility determination, and that has not already been provided, may be requested of the beneficiary.

(3) (A) If a county's efforts to obtain the information necessary to redetermine eligibility pursuant to paragraphs (1) and (2) have failed, the county shall send a redetermination form to the beneficiary, accompanied by a cover letter.

(B) The cover letter shall include all of the following:

(i) The reason or reasons explain why the redetermination form must be completed and returned.

(ii) A statement that it is not necessary to be receiving CalWORKs benefits to receive Medi-Cal benefits.

(iii) A statement that even persons who are employed may receive Medi-Cal benefits.

(C) Both the form and the cover letter shall be simple, clear, and consumer-friendly, and shall be developed by the department, in consultation with the counties and representatives of consumers, managed care plans, and providers.

(D) The redetermination form shall only request information that is subject to change, that is absolutely necessary to complete the eligibility determination, and that has not already been provided.

(E) In the case of a beneficiary from whom the county has some, but not all, of the information required in order to determine eligibility, any redetermination form sent to the beneficiary shall be highlighted to clearly indicate which information missing and must be provided by the beneficiary.

(F) The cover letter shall include a telephone number to call for more information.

(G) A beneficiary shall have 20 days from the date the form is mailed pursuant to this paragraph to respond, however, failure to respond prior to the end of this 20-day period shall not affect his or her Medi-Cal eligibility.

(4) If within 20 days of the date of mailing of a redetermination form to the beneficiary pursuant to subparagraph (C) of paragraph (3), a beneficiary does not submit the form, or submits an incomplete form, the county shall send the beneficiary a written notice of action, stating that his or her eligibility shall be terminated 10 days from the date of the notice, and the reasons for that determination, unless the beneficiary submits a completed redetermination form prior to the end of the 10-day period.

(e) To the extent feasible, the redetermination form shall be designed so that it may also be used as the annual reaffirmation form.

SEC. 8. Section 14005.38 is added to the Welfare and Institutions Code, to read:

14005.38. To the extent feasible, the department shall use the redetermination form required by paragraph (3) of subdivision (c) of Section 14005.37 as the annual reaffirmation form.

SEC. 9. Section 14005.81 of the Welfare and Institutions Code is amended to read:

14005.81. (a) Effective October 1, 1998, in addition to the two six-month periods of transitional Medi-Cal benefits provided in Section 14005.8, the state shall fund and provide one additional 12-month period of transitional Medi-Cal to persons age 19 years and older who have received 12 months of transitional Medi-Cal under Section 14005.8 and who continue to meet the requirements applicable to the additional six-month extension period provided for in Section 14005.8, *except that the beneficiary shall not be required to meet the reporting requirements imposed by federal law as a condition of receiving the six-month extension under Section 14005.8 with federal matching funds*. The benefits provided under this section shall commence on the day following the last day of receipt of benefits under Section 14005.8.

(b) In the case of an alien who has received 12 months of transitional Medi-Cal under Section 14005.8, the benefits provided under this section shall be limited to

those benefits that would be available to that person under Section 14005.8.

(c) It is the intent of the Legislature that the department seek a mechanism for securing federal financial participation in connection with pregnancy-related benefits provided under this section.

SEC. 10. The Legislature finds and declares that the provisions of Sections 1 to 8, inclusive, of this bill are necessary to meet existing federal requirements for continued federal financial participation.

SEC. 11. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

O